

The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society

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DURING THE 20TH CENTURY THE UNITED STATES witnessed sweeping social, political, and economic transformations as well as far-reaching advancements in medical diagnosis and care. Despite the dramatic changes in demography, the meaning of citizenship, and the ability to treat and cure acute and chronic diseases, foreigners were consistently associated with germs and contagion. In this article we explore why, at critical junctures in American history, immigrants have been stigmatized as the etiology of a wide variety of physical and societal ills. Anti-immigrant rhetoric and policy have often been framed by an explicitly medical language, one in which the line between perceived and actual threat is slippery and prone to hysteria and hyperbole.

Our examination focuses on three periods of immigration history: (1) the late 19th century to the passage of the National Origins Act in 1924 when millions of newcomers arrived in the United States and increasingly stringent quotas were enacted; (2) an era of retrenchment and exclusion from 1924 to 1965 when far fewer immigrants entered yet their identification with disease and contamination remained intact; (3) and the period from 1965 to the present, when family reunification

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laws became the centerpiece of immigration policy and spawned the migration of millions of Asians and Latin Americans to this country.

In each of these phases, even as the political and social currents shifted, a series of interrelated factors shaped immigrant health and health care in American society. First, the social perception of the threat of the infected immigrant was typically far greater than the actual danger. Indeed, the number of "diseased" immigrants has always been infinitesimal when compared with the number of newcomers admitted to this country. Second, Americans have tended to view illness among immigrants already settled in the United States as an imported phenomenon. Third, policy-makers have employed strikingly protean medical labels of exclusion. If authorities and anti-immigration advocates found that one classification failed to reject the "most objectionable," they soon created a new one that emphasized contagion, mental disorder, chronic disability, or even a questionable physique. Although such labels never became the primary reason for debarring specific immigrant groups, their widespread use contributed to durable biological metaphors that explained, usually in catastrophic terms, the potential risks of unrestricted immigration to the nation's social health. The association of immigrants with disease persisted even as health care improved substantially with the introduction of vaccines that all but eliminated age-old scourges such as cholera, yellow fever, and smallpox; broad-spectrum antibiotics that quelled previously devastating bacterial infections; and the development of lifesaving procedures.

As we enter the 21st century and confront a microbial universe in which epidemic diseases such as tuberculosis and HIV are becoming more prevalent and drug resistant, we need to be aware of Americans' propensity to blame outsiders for the spread of dangerous pathogens. Maintaining and protecting the public health in our current era of globalization require an ecumenical, pragmatic, and historically informed approach to understanding the links between immigration and disease.

Racial Labels and Medical Exclusion, 1880–1924

Recent scholarship has shown that public health and medicine have been crucial to immigration and the immigrant experience in American society (Kraut 1994; Markel 1997). For the most part, these studies

have concentrated on the period from 1890 to the mid-1920s, when more than 25 million newcomers arrived at U.S. ports and borders. They came primarily by sea, across the Atlantic from eastern, southern, and central Europe; across the Pacific from China, Japan, and South Asia; and also by foot across the Canadian and Mexican borders. For those who climbed aboard a steamship to their future in a faraway land, the journey was often an ordeal and, at times, risked the health of even the heartiest travelers.

In his history of the American Jewish immigration experience, *World of Our Fathers*, Irving Howe asked, "Was the Atlantic crossing really as dreadful as memoirists and legend have made it out to be? Was the food as rotten, the treatment as harsh, the steerage as sickening?" (Howe 1976, 39). To be sure, memory plays tricks on even the most logically minded, and harrowing events often become more so in the retelling. But as several immigration historians and, more important, actual participants have noted, the steerage compartments of most oceangoing vessels of this era, which carried the bulk of the passengers, offered only cramped and unsanitary quarters consisting of long tiers of berths on either side of the ship and a central area for benches and tables where immigrants took their meals. Bedding and linen were rarely provided; well-prepared immigrants brought their own. The food served onboard was often unpalatable at best and downright inedible at worst. Seasickness and its all too common companion, vomiting, were habitual features of the voyage, and open troughs and rudimentary water closets served as toilets. Sporadically flushed clean with buckets of saltwater, the facilities aboard many of these ships were foul, disgusting, and, to say the least, an imminent health hazard. Indeed, the risks of malnourishment and the prolonged debilitation brought about by these arduous conditions made these travelers susceptible to a host of medical problems. Although many immigrants were inspected by physicians before leaving Europe and Asia, especially after the passage of a series of immigration acts beginning in 1891—a time in which many now-forgotten diseases were everyday occurrences and the average life expectancy across the globe hovered at 40 years of age—few left their host country in solid health (U.S. Immigration Commission 1911).

Beginning in the 1880s and 1890s, as the pace of urbanization and industrialization quickened, many native-born Americans became alarmed at the huge numbers of immigrants arriving daily at Ellis Island and similar, but smaller, reception centers around the country. Between 1881 and

1884, approximately 3 million newcomers set foot in the United States, almost the same number of immigrants who entered the country during the entire decade of the 1870s. Between 1885 and 1898, 6 million immigrants landed, followed by 18 million between 1898 and 1924 (U.S. Immigration Bureau 1890–1924). These figures are even more significant when comparing the size of annual admissions with the size of the host society (rate of immigration). This rate reached its zenith in the first decade of the 20th century (10 to 11 immigrants arriving per 1,000 residents per year) and dropped off sharply in the aftermath of the restrictive admission policies of the 1920s, the Great Depression, and World War II. By contrast, today's wave of immigration, while in absolute numbers approximates that of the early 20th century, runs at a rate of about four immigrants per 1,000 residents per year (*Statistical Abstract of the United States* 1992).

In order to distinguish the thousands who began to disembark from steerage compartments on Ellis Island in the 1890s from earlier migrations of the English, Scots, and Irish, many turn-of-the-century American commentators began to make judgmental distinctions between “old” and “new” immigrants. The early 20th-century term *new immigrant* referred to those originating from eastern, central, and southern Europe (e.g., Russia, Poland, Austria-Hungary, the Balkans, Greece, Italy, Spain, Portugal, and Turkey), whereas *old immigrants* encompassed those coming from northern Europe (e.g., Great Britain, Ireland, Scotland, Belgium, Denmark, France, Germany, the Netherlands, Sweden, Norway, and Switzerland). Many Americans considered the “new” immigrants such as east European Jews and southern Italians, many of whom were destitute and uneducated, to be less assimilable and far more troublesome than their “old” counterparts. Between 1819 and 1880, more than 95 percent of all immigrants to the United States originated from the “old” immigrant regions, but by 1892, the peak year of immigration during the 19th century, “old” immigrants made up less than 50 percent of the total immigration. This trend intensified during the first two decades of the 20th century. For example, in 1914, the peak year of the 20th century, when 1,218,480 newcomers arrived in the United States at all ports of entry, 158,370 came from the “old” countries, in contrast to 1,051,181 from the “new,” or an 86 percent rise in “new” over “old” immigrants (U.S. Department of Labor 1916, chart 2).

Several factors converged in the late 19th century to make immigration—leaving one's native land, enduring the transoceanic passage, and

being processed upon arrival in the United States—a journey increasingly mediated by the language and practice of medicine and public health. First, the rise of bacteriology, which for the first time in human history identified microscopic organisms as the culprits of specific diseases, galvanized existing public health programs and encouraged medical authorities to believe that germs could be contained and controlled through direct intervention (Leavitt 1996). Second, during a period in which evolutionary doctrines upheld a belief in the racial degeneracy of most nonwhite groups, it was relatively easy to attribute the weary condition of some immigrants—whether impoverished, malnourished, or suffering from a particular ailment—to their biological inferiority. This circular logic meant that “new” immigrants were described alternately as swarthy, squalid, pestilent, or of “bad stock” (Higham 1988; Kraut 1994). Third, the broader medical surveillance of immigrants was part and parcel of a more overarching expansion of the federal government that entailed the subsumption of local and state public health agencies by the United States Public Health Service (USPHS)¹ (Marcus 1979). Furthermore, politicians and physicians alike began to consider a comprehensive public health apparatus as essential to making America a modern nation and inoculating the future of the country against unwanted germs from both within and without (Rosen 1993).

With the passage of the Immigration Act of 1891, a permanent foundation for the federal government’s oversight of immigration began. This and subsequent laws included detailed regulations governing eligibility for entry. In addition to bans on those with criminal records, polygamists, contract laborers, and prostitutes, this legislation excluded those persons suffering from a “loathsome or contagious disease” and required steamship companies to inspect and disinfect all immigrants before leaving foreign docks as well as bear the costs of returning immigrants who were found to be afflicted (Higham 1988; Hutchinson 1981). At the turn of the century, as the reach of the federal government extended even further, the USPHS began to occupy a more central role at the ports of entry throughout the nation, displacing local authorities. On the West Coast, for example, although the USPHS met resistance from the San Francisco Board of Health when it tried to claim jurisdiction over matters related to immigrant health inspections, the federal government eventually established control in 1910 with the opening of the Angel Island immigration station and hospital (Daniels 1997; Shah 2001). Whether entering the United States via land or water, immigrants

passed through an elaborate set of medical and psychological criteria that were quite real and frightening as the clinical gaze and diagnostic equipment of the public health physicians sized up their physical and mental condition. The overwhelming majority of immigrants passed their medical examinations and settled gradually into life in a new country. A small number, however, were turned back or detained for weeks, months, or even years at USPHS hospitals as they underwent observation and treatment for illnesses ranging from trachoma to ringworm. If not cured within a reasonable period of time, deportation—adjudicated by the immigration authorities with the input of the USPHS physicians—was typically the recommendation (Markel and Stern 1999). Nevertheless, all excludable immigrants were entitled to make their case before the Board of Special Inquiry, where immigration and public health officials offered their opinions of the desirability of the individual in question. And while a USPHS physician did not have the legal authority to prohibit entry, a diagnosis of a “loathsome or dangerous contagious disease” almost always meant deportation.

The procedure of medical inspection at New York Harbor, which from 1891 to 1924 received more than 75 percent of all immigrants, and at the other processing centers along the nation’s perimeter warrants comment. Not surprisingly, during an era in which the lines of Jim Crow segregation were being etched across the South, xenophobia against ethnic minorities was mounting, and the working class was regularly blamed for the seething class tensions and outspreading slums in American cities, the USPHS’s approach to assessing newcomers was often predicated on the prevailing racial and class stereotypes. For example, Mexican and Chinese laborers, who donned work clothes and did not display the fashionable dress of more affluent immigrants, were subjected to harsher medical scrutiny, more frequently poked for blood and urine samples, and disinfected with chemical agents (Markel and Stern 1999; Shah 2001). Indeed, it was nearly always the case that travelers in first, and most in second, class on ships and trains entering the country underwent a more much cursory appraisal than did those in steerage. In order to avoid more invasive and traumatic medical examinations, the wealthier immigrants, especially before 1907, were encouraged by European and Asian shipping agents to purchase a first- or second-class ticket in order to keep clear of the intrusive eyes of the American doctors (Fishberg 1905). Recent research regarding the Mexican border found that after the erection of medical inspection and disinfection stations

from California to Texas in the 1910s, many working-class immigrants, including Chinese, Syrians, and Mexicans, began to cross into the United States along unwatched stretches of desert or remote points along the Rio Grande in order to evade public health authorities (Markel and Stern 1999).

At Ellis Island and other stations, USPHS physicians monitored the steady stream of immigrants filing through the labyrinth of fenced-in areas, on the lookout for a list of medical and psychiatric conditions that grew longer each year (Birn 1997; Dwork 1981; Yew 1980). For example, one physician was stationed near an entryway, accessible only by stairs, where he could scrutinize newcomers hauling their suitcases and possessions for signs of shortness of breath and cardiac problems. Another physician carefully inspected the neck size and shape of those queuing before him for evidence of goiter. Yet another examined newcomers for rashes on the skin, nails, and scalp that might indicate ringworm, favus, and other fungal infections (Reed 1913a,b). Most vividly recalled by immigrants, however, was the dreaded eye examination for trachoma, which involved everting the eyelid with either the physician's fingers or an implement akin to a buttonhook (Markel 2000). Commonly used instruments were stethoscopes and, after 1910, X rays, which aided in the identification of pulmonary tuberculosis. Similarly, the tools of the bacteriology laboratory, such as microscopes, slides, stains, and culture methods, were regularly used at American immigration centers during the first two decades of the 20th century. These apparatus were crucial to the diagnosis of sexually transmitted diseases, like gonorrhea and syphilis, and parasitic infections, like hookworm. USPHS physicians also looked for insanity, hernias, rheumatism, senility, malignancies, varicose veins, poor eyesight or blindness, and a range of other infirmities (Kraut 1994).

In any year between 1891 and 1924, less than 3 percent of the total number of immigrants seeking entry to the United States were rejected for reasons of a contagious, infectious, or loathsome disease; mental disorder; or physical disability. What did change during this period was the percentage of those immigrants debarred for medical reasons out of the total number debarred for any reason (e.g., being a contract laborer, criminal, or prostitute; showing evidence of an untoward political belief system; or being deemed "likely to become a public charge"). For example, in 1898, of the total number of immigrants excluded, only 2 percent were shut out based on medical criteria. In 1913, this percentage rose to 57 percent, and by 1915, it was 69 percent. More significantly, this

proportional increase was not the result of a higher incidence of contagious or infectious disease; rather, it was due to a growing list of ailments, physical disabilities, and, over time, determinations of moral status (Kraut 1994; U.S. Department of the Treasury 1891–1901, 1902–1911; USPHS 1912–1930; Yew 1980). In other words, the creation and application of categories of medical exclusion outpaced the actual presence of disease among the newly arrived, reflecting the shift away from acute and short-lived ailments, such as typhoid and cholera, to chronic, mental, or moral conditions, such as feeble-mindedness, constitutional psychopathic inferiority, or hookworm, which began to be interpreted as likely to make an immigrant a “public charge” and an economic and social drain on the nation (Markel and Stern 1999).

Medical rejection rates varied from region to region and reflected the racial and ethnic segregation that characterized the Progressive Era. For example, between 1890 and 1924, approximately 15 million newcomers, primarily European, arrived at Ellis Island. Although as “new” immigrants they were perceived negatively by many Americans, an average of only 1 percent of them were turned back each year for medical reasons. Conversely, at Angel Island, where approximately 100,000 Chinese, Japanese, and Korean immigrants landed between 1910 and 1940, about 17 percent of all immigrants were debarred, and one-third of those were rejected because of a diagnosis of trachoma (Daniels 1997; Salyer 1995; USPHS 1912–1930; Shah 2001). Indeed, although the Chinese comprised only 1 percent of the nation’s immigrants during this period, they accounted for more than 4 percent of *all* immigrants deported each year (Daniels 1997). These USPHS interventions were based on epidemiological surveys of the region of Canton and South China, the provenance of many who set out for “Gold Mountain” and a part of the world recognized in public health studies as the globe’s foremost “hookworm belt.” Once merged with the Sinophobic attitudes of the day, however, this medical knowledge meant that stool specimens were demanded—in an atmosphere of much animosity—from almost all Asian immigrants coming into West Coast ports, but only sporadically from newcomers arriving on the Atlantic seaboard or via Mexico and Canada (Heiser 1936; Shah 2001).

Along the 2,000-mile border between Mexico and the United States, the tension between the constant demand from southwestern growers and industrialists for cheap labor and the USPHS’s mandate to protect the nation’s health created an unusual form of medical inspection

and quarantine. Until the early 1900s, Mexicans were accustomed to moving freely across the border; indeed, many considered the southwestern United States as part of their homeland (Sánchez 1993; Stern 1999). However, after the outbreak of the Mexican Revolution in 1910, U.S. immigration and health officials became uncomfortably aware of the openness of the border and the swelling circulation of insurgents, refugees, and temporary laborers. Besides being cast as transient and uprooted, Mexicans also began to be categorized as diseased and dirty. News of a typhus epidemic in Mexico's interior in 1915 and the discovery of several cases of the fever in El Paso, Texas, in late 1916 led the USPHS to launch a full-scale quarantine in January 1917. According to the USPHS physician in charge at the time, the purpose of the quarantine, which started in El Paso and soon extended to all border stations, was to disinfect and delouse all persons "considered as likely to be vermin infested" (Pierce 1917, 426). Under the constant gaze of attendants, entrants were stripped naked, showered with kerosene, examined for lice and nits, and vaccinated against smallpox. At the end of this process, the scoured clothing was returned to its owners, who also received a PHS certificate verifying that the bearer had "been deloused, bathed, vaccinated, clothing and baggage disinfected" (Pierce 1917, 428). Several months after the quarantine had been in effect, officials reported that the threat of typhus had all but disappeared. Despite this, however, medical inspections remained in force until the late 1930s; a public health response to a manageable epidemic had metamorphosed into a protracted quarantine along the entire U.S.-Mexican border (Stern 1999). Although over time a sizable number of Mexicans—especially recognized commuters, those who were well dressed, and those who rode first class on the train—were exempted from the disinfection drill, the harsh reality and duration of the quarantine helped generate and underscore stereotypes of Mexicans as impure and infectious (Sánchez 1993; Stern 1999).

Finally, along the vast Canadian-American border, where immigrants entering the United States typically underwent medical examinations along the eastern seaboard before proceeding inland and an amicable relationship existed between American and Canadian officials, the immigrant traffic was relatively light. When the newcomers in question were of British descent, questions of assimilation were easily dismissed. For those of French heritage, however, entering New England could sometimes be more difficult (Stern and Markel 1999). Frictions did arise between federal and local authorities and between USPHS officers

and immigrants, and entrants deemed “unfit” were excluded. However, for the most part, along the Canadian border, quiescence reigned: the protocol in place throughout the country was followed, but in terms of public health concerns, the situation never approached the intensity of the two coasts or the Mexican border, nor were nativist voices nearly as vociferous (Markel and Stern 1999).

Perhaps the most striking feature of the medical inspection of immigrants at different ports and borders during this era was the fluidity of the exclusionary labels themselves. Although some of the classifications were more popular in specific regions of the country, an underlying premise colored them all: immigrants threatened the health of the nation. Asians were portrayed as feeble and infested with hookworm, Mexicans as lousy, and eastern European Jews as vulnerable to trachoma, tuberculosis, and—a favorite “wastebasket” diagnosis of nativists in the early 1900s—“poor physique” (Markel and Stern 1999).

Fast-moving epidemics, such as typhoid or cholera, requiring immediate action preoccupied medical authorities from the mid-1800s to the onset of the 20th century (Rosenberg 1987). By the 1920s, however, in part due to public health campaigns, the growing popularity of personal hygiene, and for reasons that still puzzle historians, epidemics were on the wane (Rosen 1975; Tomes 1998). In order to legitimate a more enduring restriction against the menace of germs and foreigners that the rapid rise and fall of a typhus, yellow fever, or plague epidemic could not justify, immigration restrictionists began to mine the language of eugenics (Allen 1986; Kevles 1995). Relying on simplistic Mendelian theories of dominant and recessive traits, eugenicists asserted that not only did potentially infectious newcomers threaten the present with their propensity toward contagion, poverty, and alien beliefs but also their admission endangered the future of American society. Long after the admission to American ports and borders of the “neurasthenic” Jew, the “criminally minded” Italian, the grimy Mexican, or the parasite-ridden Asian, their defective genes would multiply and defile the national body (Laughlin 1923; Markel 1997).

With a protean vocabulary that connected foreign germs and genes to fears of societal disruption and the mongrelization of the American race, nativists were instrumental in the passage of the 1924 National Origins Act, which imposed exceedingly strict quotas on so-called new immigrants and debarred all Asian entrants (Higham 1988; Ngai 1999). A quota system based on national origins that clearly ranked immigrant

groups in order of desirability was inaugurated with the Immigration Act of 1921, which allowed for the entrance of 3 percent of foreign nationalities as recorded in the 1910 census. Most severely affected by these limits were the “new” immigrants, whom the vocal eugenicists of the era claimed harbored innumerable deleterious and inheritable traits. The quota system was further restricted in 1924, when the National Origins Act decreed that based on the 1890 census, only 2 percent of the foreign born of a given nationality would be admitted. Moving the source of the quota’s numerical determination back two decades, when “new” did not yet outnumber “old” immigrants, ensured only a trickle of immigrants from eastern and southern Europe, Asia, the Indian subcontinent, and the Mediterranean. One of the bill’s key sponsors, Congressman Albert Johnson (Washington) emphatically upheld the rationale behind the National Origins Act:

The United States is our land. If it was not the land of our fathers, at least it may be, and it should be the land of our children. We intend to maintain it so. The day of unalloyed welcome to all peoples, the day of indiscriminate acceptance of all races, has definitely ended. (Bernard 1980, 493)

Following on the heels of a series of progressively detailed laws dictating the entry of the foreign born—such as the 1882 Chinese Exclusion Act, the 1891 Immigration Act, and the 1893 Quarantine Act—the 1924 act represented both a crescendo of nativism and the start of a new era of immigration and racial exclusion in American society. As several scholars have argued, while still stigmatizing and severely limiting “new” immigrants, the National Origins Act nonetheless symbolically permitted them to enter the realm of white America by classifying them as Caucasian while categorically defining Mexicans and Asians as outsiders (Jacobson 1998; Ngai 1999). Whichever the group in question, however, categories of medical exclusion had become closely entwined with racial labels and perceptions of foreigners as inassimilable and diseased.

Illegal Aliens and Anticommunism, 1925–1964

After the passage of the 1924 National Origins Act and its more carefully articulated interpretations in 1927 and 1929, the rhetoric of the

biological hierarchy of races trumped all other medicalized rationales for shutting the doors to the foreign born. These laws favored immigrants whose external physical appearance most resembled the majority of white American faces and were believed to possess the greatest potential for assimilation into mainstream society. During this period, for example, northern and western European countries received 85 percent of the annual admissions visas, a number striking in both its size and its favoritism of those people that immigration restrictionists had long preferred. Nonetheless, the implementation of the quota regulations meant that only 150,000 individuals, less than 15 percent of the pre-World War I average, were eligible to come into the United States each year from all the countries covered by the National Origins Act (Ngai 1999).

As the pace of newcomers slowed, so did the patterns and perceptions of immigration. On one hand, the medical inspection process of the Progressive Era became outdated as previously frightful scourges like smallpox and plague slowly disappeared. In addition, the development and growth of air travel meant that by the end of this period, most immigrants—especially those from Europe and Asia—boarded a plane, not an ocean liner, when they set out for the United States. On the other hand, the enforcement of the quota system meant an unprecedented concern with unauthorized entry, which soon became linked to the concept of the illegal alien and, by the 1950s, to fears of Communist infiltration and subversion. Largely ignored by scholars and interpreted as uneventful, a closer examination of the period between 1924 and 1965 reveals that rather than evaporating completely, associations between immigrants and disease remained intact, albeit overshadowed by depictions of outsiders as a menace to the nation's political stability.

Immigration, of course, did continue during these decades. In all, some 7 million immigrants and another almost 5 million guest workers entered the United States between 1925 and 1964. The most significant drop in numbers occurred during the Great Depression and World War II, and for a brief time during the 1930s, more people left the United States than entered. Between 1930 and 1945, fewer than 700,000 immigrants arrived, in contrast to the more than 5 million immigrants who came to the United States between 1915 and 1930. The paucity of entrants is evidenced by the fact that even with the reductions enforced by the National Origins Act, between 1930 and 1947 only 23 percent of all available immigrant quota slots were used (Ueda 1994; U.S. Congress 1950). During this period, the densest immigrant traffic flowed along

the Canadian and Mexican borders, not into the once crowded buildings of Ellis Island and Angel Island. And while the USPHS authorities continued their inspections, public health became a secondary issue and imported disease a more latent concern.

Instead, the economic and political demands brought on by the pressures of World War II and the cold war came to the forefront of immigration policy. By the late 1930s, for example, the quarantine procedures along the U.S.–Mexican border, prompted by the typhus outbreak in 1917, were terminated, and as was the case across the board, the responsibility of examining immigrants was transferred to contracted doctors and consular offices in the sending country. So many Mexicans had left the United States during the Great Depression that in 1942, when industrial and agricultural laborers were needed during the war, a novel binational guest worker arrangement was established to lure Mexicans back. Lasting until 1964 and designed to fill shortages in the factories and on the fields, the Bracero Program sought simultaneously to monitor the movement of Mexican transmigrants and to place them in factories and fields to aid the war mobilization. Critics of this program derided it as nothing more than a vehicle for an “endless army” of cheap labor for American growers (Calavita 1992). Most Mexicans who stayed in the United States settled in California and the Southwest, with smaller yet substantial numbers migrating to the great industrial cities of the Midwest and Northeast. Not subjected to the quotas of the National Origins Act and allowed to enter the United States under the Bracero Program, yet tracked and often harassed by the Border Patrol, Mexican immigrants were in an exceedingly vulnerable and ambiguous position. During this period they gradually came to be identified as the quintessential “illegal aliens” and, when McCarthyism reached its apex in the early 1950s, were subjected to the militaristic purges of Operation Wetback, an undertaking in which nearly 4 million Mexicans, both documented and undocumented, were rounded up in factories, restaurants, bars, and even private domiciles and then expelled (Jacobson 1996; Massey 1986; Ngai 1999; Ueda 1994).

During these years, European immigration, above all from the “old” countries, fell sharply, and disease ceased to be one of the primary considerations for evaluating recent arrivals. Nevertheless, this era’s immigration policy did have unforeseen deadly consequences as the Third Reich rose and fell. The American response to the refugee crisis created by Hitler’s genocidal rampage was appalling in its impotence, yet the

Roosevelt administration's disinterest in saving Jews was rarely couched in metaphors of disease and biological inferiority, in contrast to those of the governments in countries like Brazil and Argentina (Lesser 1995; Wyman 1968, 1985). Occasional appeals to save the lives of Jews and other victims of Nazi persecution were made during the late 1930s and early 1940s, but relief efforts were minuscule in proportion to the need. More often than not, Americans simply ignored the problem. After the end of World War II and the "discovery" of Nazi atrocities, U.S. refugee policies became somewhat more liberalized, particularly for displaced refugees and those aliens who were either children or spouses of American service men and women. As a result, these years witnessed a small rise in European entrants and after 1943, when the Chinese Exclusion Act was rescinded, in Chinese immigrants now able to claim their quota allotments.

One significant change that had a major impact on both the public health and the immigrant experience during this period was the transformation in modes of travel. Angel Island closed in 1940 after a devastating fire, and Ellis Island shut down in 1954. Following World War II, as air transportation became the norm, travel time was markedly shortened, causing public health officials to worry about the risks of passengers introducing diseases, especially infections. Given the incubation periods of many dangerous conditions, which ranges from a few days for cholera to days or two weeks for typhus fever, steamship travel at least gave medical inspectors a week for an infection to manifest itself in the lapse between an immigrant's departure and his or her arrival. Consequently, in the early 20th century, it was expected that the most acutely ill immigrants would be readily apparent to the USPHS physician. But with the advent of air travel, it was now possible for an asymptomatic yet highly infectious person to set foot in the United States and, in less than 48 hours, become deathly ill and spread germs to an unsuspecting American public. As a result, a number of federal agencies, civil aviation boards, physicians, public health experts, and representatives of the airlines began meeting and holding hearings to update the medical inspection process. Not unlike the countless hearings and discussions held between members of Congress and the steamship companies at the turn of the 20th century, the airlines cooperated with immigration officials at the same time as they guarded their burgeoning industry (National Archives 1946).

Moreover, by this time, most medical inspections were conducted well before the immigrant left his or her country of origin, as a chain

of checkpoints was instituted for long flights, with frequent stopovers to ensure that a passenger who became acutely ill en route was quickly examined and, if necessary, isolated. Such was the case of Guido Castro Quesado, a 43-year-old immigrant from Costa Rica who flew to Texas in late 1943 seeking treatment for neurosyphilis. He was barred from entry and returned by January 1944 (National Archives 1944). During these years, the risks of swift travel and the transmission of germs from one part of the globe to another became pressing considerations for public health officials and citizens at large. An awareness of the new mobility of germs, however, also coincided with a striking worldwide diminution in the incidence of the classic and most rapidly lethal epidemic diseases equated with earlier waves of immigration. After the development of antibiotics and a host of preventive vaccines in the postwar years, the hue and cry about imported scourges became moot when compared with the fears earlier expressed by nativists and public health.

Above all else, the perceived threat of Communism and other political ideologies considered “un-American” framed immigration policy in the late 1940s and 1950s as a number of laws were passed, most infamously the Internal Security Act of 1950, which prohibited the entry or settlement of immigrants who either were or had been Communists. Indeed, the cold war facilitated a close partnership between those advocating immigration restriction and national security (Divine 1957; Ngai 1998; Schrecker 1998). While never a major chord, the themes of diseased immigrants, inferior races, and other biological explanations did insinuate themselves into the rationales behind ongoing immigration restriction. This was illustrated by both popular representations of disease and public health in American film and the hallmark piece of immigration legislation of this period, the Walter-McCarran Act.

In August 1950—just six months after Senator Joseph McCarthy of Wisconsin set in motion the era that bears his name by announcing before the Republican Women’s Club of Wheeling, West Virginia, that he had in his hand a list of more than 200 Communists working in the U.S. State Department—the film *Panic in the Streets* was released. Directed by Elia Kazan, who two years later stood before the House Un-American Activities Committee and “named names” of purported Communists working in Hollywood, this film captures the tenacious association between germs and foreignness in American society. Set in the humid port city of New Orleans, *Panic in the Streets* tells the story of an outbreak of pneumonic plague that is being spread by a low-class and

gambling outsider who is described alternately as Armenian, Argentine, or Greek (Murphy 1950). The hero in this film noir is a USPHS officer, Dr. Clinton Reed, played by Richard Widmark, who is portrayed as the classic family man of the 1950s, torn between the exhausting demands of his civil service job and his desire to be a more devoted father and husband. Following the script of American individualism, Widmark is the only character who can steer the correct course, safeguard the public, and insulate New Orleans, the nation, and the world from a devastating and fatal epidemic. In his quest to eliminate the source of the bacteria, he incinerates the body of the deceased plague carrier; wages a fierce battle of sterilization, inoculation, and serum injections; and combs the city's seedy underworld of dock workers, gamblers, and gangsters looking for those who came in contact with the sick and shady foreigner. In this film, plague is depicted as an alien disease brought into the United States by nonnatives speaking with thick accents. Indeed, Widmark refers to an earlier USPHS effort, in 1924, to quarantine plague in Los Angeles when it broke out in a Mexican community (Deverell 1999; Visellear 1974). In the end, Widmark triumphs despite jurisdictional clashes with the local police and municipal authorities, and the film's primary villain, the brutal gangster Blackie, is trapped like vermin by a rat catcher on a ship's mooring line and plunges into the water. Like the ideal cold war husband, Widmark returns home to the arms of his adoring, pregnant wife and admiring son.

With regard to immigration policy, by the close of World War II, it was clear to policymakers that the relentlessly amended collection of laws enacted between 1891 and 1950 was unwieldy and confusing and required serious revision or, at least, clarification. Taking the lead in crafting a new omnibus immigration bill was Senator Patrick McCarran of Arizona. An ardent anti-New Dealer and a staunch conservative who viewed himself as a bona fide defender of American society from unwanted intrusion and infiltration, McCarran collaborated closely with McCarthy in the campaign against the alleged Communist subversion. In 1950, McCarran spearheaded sponsorship of the Internal Security Act. Two years later, he and Congressman Francis Walter of Pennsylvania embarked on the elaboration of what ultimately became the Immigration and Nationality Act, or the McCarran-Walter Act, of 1952.

The solution they reached was a revamped code of immigration laws that introduced selective admission categories based on job expertise and the permanent residence of the immigrant's immediate family members

in the United States. The bill retained the quota system for European immigrants, which numerically favored western and Nordic Europeans over eastern and southern Europeans; released some additional slots for Asians; and widened the grounds for debarring immigrants with criminal records and chronic diseases. As historian Robert A. Divine noted, implicitly embedded in the McCarran-Walter Act were two opposing philosophies. Restrictionists like McCarran and Walter believed that immigration was a source of danger to the United States and that laws were needed to guard American institutions and traditions. Their opponents argued that immigration was a source of strength and urged a policy that expressed generosity and a helping hand to the oppressed people of the world (Divine 1957).

In McCarran's anti-immigration rhetoric against east European Jews, southern Italians, Asians, and other so-called undesirables were deep-seated metaphors of disease and contagion. As floor manager of the bill during its final debate in the Senate in mid-May 1952, McCarran made an impassioned plea to save the United States from imported ruin:

Today . . . as never before, a sound immigration and naturalization system is essential to the preservation of our way of life, because that system is the conduit through which a stream of humanity flows into the fabric of our society. If that stream is healthy, the impact on our society is salutary; but if that stream is polluted our institutions and our way of life becomes infected. (*Congressional Record*, May 13, 1952, 5089)

More significantly, this language of exclusion revealed the continuing malleability of the "undesirable immigrant" classification and the resurrection of the association between germs and foreigners that marked the Progressive Era. For example, in the law's general categories of ineligible aliens, we find—in no explainable order of actual threat—the feeble-minded; the insane; people with epilepsy or other mental defects; drug addicts and alcoholics; those with leprosy or contagious diseases; aliens found to have a physical defect, disease, or disability that would restrict their ability to earn a living; the impoverished; criminals; polygamists; prostitutes; homosexuals; contract laborers; and Communists, anarchists, or those subscribing to totalitarian political ideologies (U.S. Immigration and Nationality Act of 1952). The McCarran-Walter Act defined undesirability along a spectrum that was both specific enough to keep out those identified as minatory and loose enough to encircle newer

perceived threats to the American way of life. This formula of this series of analogies could be summarized as

Disease = Criminal Behavior = Poverty = Addiction = Immoral Behavior = Communism

The law was vetoed by President Harry Truman, who contended that the bill would not successfully modernize American immigration policy, admonishing its reliance on a national origins quota system designed to keep immigration at a low level:

We do not need to be protected against immigrants from these countries. On the contrary, we want to stretch out a helping hand. . . . The greatest vice of the present quota system . . . is that it discriminates, deliberately and intentionally, against many of the people of the world. . . . It is incredible to me that, in the year 1952, we should again be enacting into law such a slur on the patriotism, the capacity, and the decency of a large part of our citizenry. (*Congressional Record*, June 25, 1952, 8083).

Despite the presidential warning, Truman's veto was overridden, and the bill became law on June 27, 1952 (*Congressional Record*, June 26–27, 1952). Although from this moment on, American presidents—from Truman and Eisenhower to John F. Kennedy—began advocating a more liberal and fair-minded immigration policy, this did not become a reality until Lyndon Johnson signed the Hart-Celler Immigration Act of 1965.

The Newest Immigrants and the Recrudescence of Old Fears, 1965–Present

Speaking from a podium at Liberty Island in New York Harbor in October 1965, just under the outstretched arm that had both welcomed and shunned newcomers, President Johnson explained to his audience that while

the days of unlimited immigration are past . . . the immigration policy of the United States has been twisted and distorted by the harsh injustice of the national origins quota system . . . [according to which people] of needed skill and talent were denied entrance because they came from southern or eastern Europe or from one of the developing countries. (Johnson 1966, 1038–9)

This philosophy bolstered a much more relaxed attitude toward immigration in the latter third of the 20th century and reopened the gates to new generations of arrivals, especially from Latin America and Asia. This period was punctuated, however, by a resurgence of nativism in the 1980s that was sparked by the advent of AIDS, tied to worries about the browning of America, and drawn from decades-old stereotypes of outsiders as either acutely or chronically ill (Nelkin and Michaels 1998; Perea 1997). In the 1990s, federal and state chambers debated the need to restrict state services, particularly health care, to the under- and undocumented (Markel 1999). More recently, the emergence of multidrug resistant strains of HIV and tuberculosis have reignited the persistent association between foreigners and germs, which works against the effective and judicious management of global public health (Brimelow 1995; Edwards 2001; Farmer 1999).

The Immigration Act of 1965 was cosponsored by Senator Philip A. Hart of Michigan and Congressman Emmanuel Celler, who represented New York City's ethnically diverse Tenth Congressional District in Brooklyn. It constituted one facet of a larger trend of social activism that encompassed the Civil Rights Act of 1964 and the Voting Rights Act of 1965, as well as the beginning of the Vietnam War. The center of the Hart-Celler Act was an immigration policy that emphasized reuniting immediate family members of already settled immigrants and attracting highly educated and occupationally skilled immigrants. An initial ceiling of 290,000 admissible immigrants per year was instituted, with 170,000 slots for the Eastern Hemisphere and 120,000 for the Western Hemisphere, marking the first time that Latin American and Caribbean immigrants were subject to numerical limitations. Nonetheless, the Hart-Celler Act's abolition of the national origins quota system had an unexpected consequence: a large increase in U.S. immigration rates (Reimers 1992; Ueda 1994).

Each year after 1965 the number of immigrants entering the United States rose as family reunification enlarged, almost exponentially, the pool of eligible visa applicants. While the 1970s averaged 450,000 newcomers annually, by the 1980s, this figure had risen to 730,000, along with an estimated 200,000 undocumented entrants. These newest immigrants were more heterogeneous than their former counterparts, coming, literally, from every corner of the world and representing greater socioeconomic diversity (Ueda 1994). Whereas the majority of the "new" immigrants of the Progressive Era were working class, the post-1965

generation was composed of both laborers, often with scant education, and skilled professionals and trained workers. Seventy-five percent of the newest immigrants settled in six states: California, New York, Texas, New Jersey, Florida, and Illinois (U.S. Select Commission on Immigration and Refugee Policy 1981). Intensely concentrated settlement patterns in the largest American cities made many of the latest—particularly the unskilled and Latino—arrivals much more visible and prompted many Americans to assert that unwanted foreigners were inundating the country. In 1986, in order to gauge the tangible quantity of illegals, especially Mexicans, and absorb those who had resided unlawfully in the United States since 1982, Congress passed the Immigration Reform and Control Act, which offered amnesty to many undocumented workers and attempted to prosecute the American employers who had wittingly hired them (Zolberg 1990).

During this period, large international airports such as John F. Kennedy in New York, O'Hare in Chicago, Miami International, San Francisco International, and Los Angeles International consolidated their position as the nation's principal ports of entry, just as Ellis Island, Angel Island, and El Paso's immigration station had been in times past. Moreover, by this time, immigrants coming to the United States were generally healthier people. After World War II, many countries built hospitals and rural clinics and spearheaded campaigns to combat endemic diseases, and many parts of the world benefited from reductions in childhood mortality and various infectious diseases as well as improved standards of nutrition as a result of hygiene and maternity programs. In addition, organizations like the United States Peace Corps and the United Nations World Health Organization brought modern sanitary techniques, public health administration, vaccines, and medical treatments to areas that had neither the financial or human resources to afford them. But these enhanced living conditions and lowered mortality rates had the ironic outcome of skyrocketing populations. People facing overcrowding and few opportunities now had powerful incentives to immigrate, especially to the United States. And come they did, whether by jet, rickety boat, plane, or foot. In 1990, for example, more than 1.8 million legal and approximately 300,000 illegal newcomers entered the United States. Immigration was now truly global, primarily from Asia, Mexico, and the Caribbean; the majority of the newest immigrants were people of color and far more likely than their predecessors to settle permanently in the United States.

One thing had not changed, however: the assumption that many infectious diseases originated beyond American borders and were trafficked in by foreigners. This perception was supported by immigration health policy, which required only potential immigrants and visa solicitors, not visiting travelers or American citizens returning from abroad, to undergo medical examinations before leaving their countries of origin. Thus, the realistic menace of imported germs—which scorn all boundaries and can incubate just as elusively and easily in an American tourist heading back from a vacation in the Bahamas as in a Russian visa applicant seeking to join her relatives in Chicago—was eclipsed by the recalcitrant connection between foreigners and disease.

In the context of resurgent anti-immigrant sentiment in the 1980s, calls to protect the public health from external hazards began to be sounded in tandem with the escalating AIDS epidemic. For example, in 1986, the USPHS suggested adding AIDS to the list of infections that would automatically debar a prospective newcomer. Senator Jesse Helms of North Carolina, a noted opponent of both gay rights and AIDS research, treatment, and prevention, subsequently introduced a bill that made AIDS an excludable disease for immigrants. President George H.W. Bush's secretary of health and human services, Louis Sullivan, a physician, publicly stated that only tuberculosis should be defined as a "communicable disease of public health significance," yet the regulation, passed in 1987, remained in effect until 1991 when the policy was changed only slightly: HIV-positive "travelers" could enter the United States, but immigrants wishing to take up permanent residence were banned. The message was clear: tourists with money were welcome, but impoverished and potentially ill immigrants, "likely to become a public charge," were not (*Federal Register* 1986, 1987; Markel 1990). All newcomers seeking refugee status at a U.S. embassy in their nation of origin were tested for HIV; those seeking asylum were allowed to live in the United States for a year, but if they wished to stay longer, they had to submit to an HIV test.

The actual number of immigrants sent back for being HIV positive was not particularly high. In 1989, for instance, the National Commission on AIDS estimated that fewer than 1,000 immigrants with HIV/AIDS would seek entry into the United States during that calendar year. At the same time, Dr. June Osborn, the chairperson of the commission, observed that the current policies "fly in the face of strong opinion and practice and lead to unconscionable infringement of human rights and dignity,

and they reinforce a false impression that AIDS and HIV infection are a general threat when in fact they are sharply restricted in their mode of transmission" (Cohen 1989; Farmer 1992; National Commission on Acquired Immune Deficiency Syndrome 1989).

The AIDS regulations reiterated a recurrent theme in American immigration policy, that specific "undesirable" groups were labeled as being "high risk" whether or not they actually posed a threat of transmitting disease. Given the policy of more than a century of regulating the entry of people with identified infectious or contagious diseases, it was hardly surprising that HIV-positive status could be used to reject an entrant. However, when AIDS appeared suddenly in the 1980s, it was quickly conflated with deviant sexuality and several minority groups, ranging from gays and intravenous drug abusers to Haitians and Africans. As a disease category, it shared much with the feared killers of the past, such as tuberculosis and syphilis, could be understood in terms of the labels of moral undesirability articulated in the McCarran-Walter Act, and, moreover, was racially tainted by fantastical theories tracing the etiology of HIV/AIDS to Haitian voodoo rituals and animal sacrifice (Fairchild and Tynan 1994; Farmer 1992).

More than five years after it was scientifically established that HIV could be transmitted only through bodily fluids such as blood and semen—as opposed to casual contact—the potency of AIDS stereotypes nevertheless led the Immigration and Naturalization Service (INS) to quarantine HIV-positive Haitian immigrants at the U.S. Marine Base at Guantánamo Bay, Cuba (Annas 1993). From 1990 to 1993, these detainees were separated from other Haitian émigrés who had been intercepted at sea and held in unsanitary conditions far worse than those of their predecessors at Ellis Island (Hilts 1992). In fact, the situation was so severe that in 1993, a federal district court judge, Sterling Johnson of Brooklyn, ruled that the Immigration and Naturalization Service had denied these immigrants adequate medical care and legal consul (*Haitian Centers Council v. Sale* 1993).

Once faced with this judicial reprimand, supporters of the HIV ban on immigrants replicated a pattern of the early 20th century when nativists turned toward eugenics and arguments of cost to explain why admitting foreigners would, over time, drain America's coffers. Now less focused on the panic that outsiders would spread AIDS throughout the United States and aware also that 650,000 to 900,000 American citizens were HIV positive, they emphasized instead the fiscal burden of having to care

for sick newcomers (Gostin et al. 1990). Accordingly, in February 1993, Senator Don Nickles of Oklahoma introduced a bill prohibiting the entry of HIV-positive immigrants on economic grounds, which passed in the U.S. Senate, 76 to 23, with an even larger show of support in the U.S. House of Representatives a few weeks later. Despite the opinion of many immigration and public health experts that the migration of HIV-positive persons to America would be minimal, Senator Nickles's warning in a well-publicized speech of the need to guard the nation from a "communicable disease" rang true for many Americans: "If we change this policy, it will almost be like an invitation for many people who carry this dreadful, deadly disease, to come into the country because we do have quality health care in this country . . ." and will "jeopardize the lives of countless Americans and will cost U.S. taxpayers millions of dollars" (*Congressional Record*, February 17, 1993, 2865).

On June 10, 1993, President Bill Clinton signed into law the National Institutes of Health Revitalization Act, which amended the Immigration and Nationality Act of 1988, adding HIV infection as a criterion to keep out immigrants. The reasoning behind this law was to shield the United States against external pathogens and the expense of providing medical care to foreigners, concerns that also were evident in the logic of the contemporaneous California Illegal Alien Statute, approved in 1994 by a majority of California voters who resented the putative taxpayer burden of public and country medical care (Reimers 1998). Known colloquially as "Proposition 187," this state law required publicly funded health care facilities to refuse care to illegal immigrants and mandated that health care workers who suspected that one of their patients might be an illegal alien report him or her to the Immigration and Naturalization Service, the state attorney general, and the state director of health services (Ziv and Lo 1995).

Contested to this day in the courts at the insistence of a number of immigrant advocacy groups, the law has never been formally implemented (Purdum 1999). Nevertheless, this kind of proposition not only imperils the frank discussion vital to a doctor-patient relationship, and if it were ever successfully enforced, it would seriously undermine the public's health. Consider, for example, the plight of undocumented citrus pickers in the California valleys. Lured across the Mexican border in the hopes of earning higher wages in the United States, these laborers live and work in difficult and unsanitary conditions, which put them at significantly greater risk of contracting tuberculosis and other ailments.

With the sword of deportation hanging over him, an undocumented immigrant with tuberculosis and a productive cough—whether he contracted it in his native country or the United States—would be reticent to seek medical attention (Markel 1999; McKenna, McCray, and Onorato 1995). Indeed, legal and illegal immigrants in California avoided health care providers in during the months immediately after the passage of Proposition 187, a predicament that puts all American citizens in jeopardy (Asch, Leake, and Gelberg 1994). Some recent studies of the public health risks of tuberculosis around the world recommend that instead of forcing undocumented immigrants to hide from physicians, the United States and other industrialized nations create user-friendly tuberculosis detection and treatment programs for the hundreds of millions of people who cross international boundaries each year (Bloom 2002; Bloom et al. 1999; Farmer 1999; Geng et al. 2002; Reichman 2002; Sachs 2002). Such an arrangement was recently implemented by the U.S.-Mexican Border Health Commission to track and care for Mexican transmigrants afflicted with HIV/AIDS, hepatitis A, or tuberculosis (Smith 2001). Especially novel is the creation of a confidential binational tuberculosis card that allows patients to obtain treatment in both the United States and Mexico without fearing deportation or long-term detention in one of the many TB screening centers along the border (Sachs 2000). As Dr. Lincoln Chen, a public health expert from the Rockefeller Foundation, stated, such initiatives make the U.S.-Mexican border a model for other possible multinational efforts and “the cutting edge of health in the 21st century . . . this is the front line of global health” (Smith 2001, A19).

Protecting the Public Health in a Global Millennium

In order to protect the public health of Americans today, the all too common tendency to conflate disease with foreigners and/or specific ethnic, racial, or sexual minorities must be held in check by discovering where the risk factors for public health threats actually lie. At many points over the past century, some people have wanted to exclude persons perceived as foreign, inassimilable, and dangerous to the country's social, political, or economic fabric. Metaphors of germs and contagion have never lurked far beneath the surface of such rationales. As we have shown,

more often than not these arguments have been motivated by, and closely intertwined with, ideologies of racialism, nativism, and national security rather than substantiated epidemiological or medical observations. Not surprisingly, these attitudes have deterred rather than encouraged many immigrants from seeking medical care. As the 20th century came to a close, the associations between immigration and disease remained powerful and prevalent.

The world we inhabit today is essentially a global village. Ideas, goods, and people can now travel long distances in a matter of hours. More compelling, microbes are not required to carry passports and can easily escape the best-laid plans to block their entry. Safeguarding America's health means safeguarding the world's health. If any concept in this brief history of immigration and public health is antiquated, it is the idea that infectious diseases can be controlled by targeting certain populations based on apparent ethnic or national background. The Ellis Island model of medical inspection is not appropriate to our current era, and it is fitting that this symbol of American immigration history is now a museum. Moreover, economists and experts in global public health have demonstrated that the most humane, effective, and fiscally sound approaches are those in which wealthy nations, organizations, and corporations come to the assistance of poorer nations in order to protect all the world's citizens. In the 21st century it is no longer acceptable or wise to consider that an epidemic brewing in Zaire is either remote or irrelevant (Garrett 1994, 2000; Markel 2003).

The presence of serious public health risk factors—including soaring rates of tuberculosis, malaria, and emergent or poorly understood infectious diseases; shrinking economic resources for epidemiological surveillance and the delivery of primary care; and the recognition of the profound mental health disorders generated by genocidal practices in the war-torn countries of Africa, the Middle East, and eastern Europe, not to mention the prospects of bioterrorism—all point to potential episodes in which the appearance of a specific epidemic disease may again be associated with foreigners (Drexler 2002; Miller, Engelberg, and Broad 2001; Tucker 2001). While we should never expect that our responses to such potential crises will be perfect, we can learn from the mistakes of the past in order to better balance between combating and containing specific diseases and scapegoating a particular group.

ENDNOTE

1. Before 1902, the Public Health Service was the United States Marine and Hospital Service. After 1902, it was designated the United States Marine Hospital and Public Health Service, and in 1912, it became the United States Public Health Service. For simplicity's sake, we refer to it as the U.S. Public Health Service, or USPHS, throughout this article.

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